Editorial Norman Goldstein MD

Aloha to Samuel D. Allison MD

Sam Allison, past president of the HMA and the *Dean of Hawaii Dermatologists*, is moving back to the Mainland.

When your editor came to Hawaii 31 years ago, there were three "great names" in Hawaii dermatology—not just men known and respected in Hawaii, but on the Mainland and around the world as well. Harry L. Arnold Jr, or "A_2", served as editor of the *Journal* for more than 40 years. Harold "Skin" Johnson came to Hawaii in 1940 and practiced in the Alexander Young Hotel Building. And then there was Sam Allison, the renowned VD authority.

Sam and I attended New York University, Bellevue Hospital: He in 1948; I in 1961. But his name was legendary to me long before I arrived in Hawaii. Sam Allison directed the Hawaii Territory Health Department's Bureau of Venereal Diseases from 1942 to 1945—very busy years for a dermatologist/syphilologist. At the onset of World War II, there were at least 20 houses of prostitution on Oahu, employing at least 250 women. With the tremendous influx of men, the prostitutes worked shorter hours and more rapidly(!) until they had reduced their average time of contact with their customers significantly.[1]

Sam's classic VD article, *Venereal Disease in Wartime Hawaii*, also included photos of brothels in Honolulu and the ubiquitous Board of Health prophylaxis placard with a handwritten special notice, "Time Limit: 5 minutes. No Money Back."

Another of Sam's major contributions was *Social Protection in Hawaii—How the City of Honolulu Closed its Red-Light District.* (Sam, we can still use your help!)[2] Sam also wrote a *VD Manual for Teachers* and *The Story of VD* for intermediate and high schools in the territory.

After more than 50 years of living in Hawaii and more than 50 publications and numerous board memberships, including editorial board of the *Hawaii Medical Journal*, Sam will be moving soon.

Cecil and Sam recently celebrated their 57th wedding anniversary. They will be living on the East Coast to be closer to their daughter Kathryn and her family.

Sam, we are saddened to say *aloha* to you and Cecil. You have had a tremendous influence in dermatology and all of medicine in Hawaii. We could use your help in eradicating the AIDS problem as you did with syphilis and gonorrhea.

On behalf of your colleagues in Hawaii, *mahalo nui loa.*

Norman Goldstein, Editor

References

1. Allison SD. Venereal disease in wartime Hawaii. *Am J Syph Gon and VD.* 1947;5: 545-558.
2. Snow WF, Laune FF, Allison SD. Social protection in Hawaii—How the city of Honolulu closed its red-light district. *J Soc Hyg.* 1946;2:Pub A661.

Editorials

A Common Sense Prescription for Health Care

There are a number of myths about health care in the United States. The biggest is that we are in a "health care crisis." Yes, we need to improve the system, but we should avoid the massive controls suggested by the Clinton administration.

We have the greatest health care system in the world! The world envies us; people come from afar to receive care in our facilities. There is no health care crisis!

There are approximately 40 million people without health insurance (about 15% of the population). Of the most vulnerable:

- The aged are covered by Medicare.
- The poor are covered by city, state, and federally funded programs and not-for-profit health care organizations.

Must uninsured adults are between jobs or working at low-wage jobs. Half are under 30. Three-quarters are covered again within a year. Better ways are needed to help these individuals without overhauling the entire system. Aiding individuals would cost less money than changing a system that works for about 85% of the population.

However, the Clintons and some in Congress seem intent on changing the entire health care distribution system. They are heading in a direction that will dramatically increase government control and costs while reducing an individual's involvement in personal health care decisions. Hopefully, an informed public can help these leaders have a change of heart.

There are three variables in medical care. It should be:

- High quality, high-tech.
- Rapidly and easily accessible.
- Economical.

Unfortunately, we can have only two out of three.

In the United States, we focus on the first two variables. We have the best medical care in the world, it uses technology extensively, and it is available almost immediately. Health care is not rationed or delayed as is the case in the United Kingdom or Canada.

The cost of medical care in the U.S. is high, but we pretty much get what we pay for. More than that, any person who has had a lifesaving experience with our medical care system will tell you that the benefits are incalculable.

The good news is that we can improve our medical care system by doing a few simple things that will decrease government involvement and put individuals back in charge of their health care decisions:

- **Get the lawyers out of health care.**

Malpractice insurance is a pre-payment of lawyers' fees, which can run up to half of a malpractice award. It costs every person in the U.S. hundreds of dollars annually.

In addition, too many unnecessary x-rays, lab tests, and procedures are ordered to position the physician, clinic, or hospital in the event of a malpractice suit. The price of so-called "defensive medicine" is astronomical.

This could be reduced if every state developed a schedule of payments to settle malpractice claims. Expert arbitrators would review claims. If there were charges of malpractice, the arbitrators, not lawyers, would order a financial settlement based on the schedule.

• Make all health care equally tax deductible.

Currently, part of health care is tax deductible by individuals and employees.

But some people have to buy their own health insurance policies or pay health care bills using after-tax dollars.

Let's make health care equally tax deductible and give everyone a tax deduction for what they spend on health insurance and health care.

• Let individuals make health care cost decisions.

If the cost of health care and health insurance were tax deductible and self-monitored, individuals suddenly would be intimately involved in their health care cost decisions. They would seek physicians, hospitals, and insurance policies with the best monetary value. Before using health care services, patients would ask about the costs and alternatives. Millions of individuals would police the health care market instead of government bureaucrats, insurers, and employers.

• Make it possible to buy customized, no-frills, affordable insurance.

Legislators in many states have pushed the price of individual and small-group insurance policies out of the reach of low and middle-income workers by requiring carriers to include benefits such as treatment for drug abuse and alcoholism, and the services of psychologists, chiropractors, acupuncturists, and naturopaths. The result is that healthy young persons or persons between jobs who need health care coverage only for catastrophic illness, find the cost of health care insurance outrageous, and are being asked to subsidize care neither wanted nor needed.

We need to free insurance companies so that they can offer no-frills, basic, affordable insurance to those who want only that kind of protection.

• Make it possible for insurance carriers to charge fair prices for health care.

Many states dictate that in pricing health care insurance carriers adopt "community pricing" or "one-price-for-all." That means that young, healthy people with good lifestyles are being forced to subsidize health care for those with unhealthy habits such as alcoholism, drug abuse, etc.

We should free the insurance companies from these restrictions and allow them to price insurance based on age and lifestyle categories, much like life and auto insurance policies are priced.

Recognizing that this would increase health care costs for some, we also should have a system of subsidies so that all can afford basic medical insurance.

In summary, we have an excellent health care system. It is not in crisis. The institution of medical reform, equal tax deductibility, individual responsibility for the payment of medical costs, no-frills insurance, and fair-priced insurance would reduce the costs of medical care without affecting quality and access. That also would allow us to focus on those who need financial assistance so that all can be included in the world's finest medical care network.

Richard R. Kelley MD

Richard Kelley MD is well known to Hawaii's medical community and the visitor industry. Rich attended Punahou School, Stanford and Harvard. He served as a pathologist at Queen's and later Kapiolani Hospitals. In the 1970s ,the call of the family hotel chain beckoned Rich to retire from medicine and take over Outrigger Hotels Hawaii.

Rich Kelley wears many, many hats, but still he is very concerned with medicine in Hawaii. In this guest editorial, Dr Kelley presents his views forthrightly and clearly—the views of a physician and a businessman—a great combination. Mahalo, Rich, for your many contributions to education, medicine, and tourism in Hawaii.—ED.

Letter to the Editor

The *Journal* welcomes letters in good taste on any topic. All letters must be signed with the writer's correct signature and include the address and telephone number for our verification. Letters should be on a single subject and no longer than 200 words. Letters of any length may be trimmed.

Send to: Letters to the Editor, Hawaii Medical Journal, 1360 S. Beretania Street, Second Floor, Honolulu, HI 96814.

I was pleased to read Irwin Schatz's article, "On the Quest for the Humane Physician" (*Hawaii Med J.* 1994;53:196-199) and would have liked to have heard the original unedited presentation. Now 26 years out of medical school and with little ensuing contact with academia, I am a bit dated, but it doesn't sound like much has changed since my departure.

I would like to suggest that the primary origin and solution to the problem lies not somewhere in society but in medical school itself. Dr Schatz suggested as much, but failed to allow the buck to stop there. Interestingly, the medical school effects he does mention are primarily those of policies, programs, and technology rather than persons.

Medical schools are responsible for selecting their own students, but, unless a lot has changed since the sixties, they are selected for qualities allowing them to be successful medical students rather than good physicians. Furthermore, medical school professors are academicians and their first priorities rarely are patient care. Often they consider academic medicine to be a higher calling than practice. I recall reading a report a few years ago that ranked the nation's top medical schools giving Harvard the prize. The primary criterion? Harvard had the most medical school professors among its graduates.

Medical schools also are responsible for selecting their own faculty, and it is unlikely that humaneness is one of the criteria. Medical students and house staff are incredibly impressionable and eager to model themselves after mentors whom they consider attractive. Many professors are excellent, humane physicians, but many are not and it takes fewer to make it bad than it does to make it good. If the primary behavioral values being demonstrated do not include humaneness as superordinate, behaving humanely will be an individual accident. It was refreshing to have Dr Schatz debunk the absurd contention that